REQUEST FOR OUT OF STATE WORKER'S COMPENSATION COVERAGE

Employee Name: _____

Permanent Address: _____
City, State or Province _____
Country & Zip (Postal) Code _____
Phone Number: _____

Work Residence: _____
City, State or Province _____
Country & Zip (Postal) Code _____
Phone number: _____

OUT OF STATE EMPLOYMENT

Date of Hire: _____ Place of Hire: (specify state) _____

Method of Hire: ☐ In Person ☐ By Phone ☐ By Mail ☐ Other Contract: ☐ Written ☐ Verbal

Start Date: _____ Anticipated Ending Date: _____ Est. Annual Salary: _____

Job Class: _____ Social Security #: _____

Job Duties: _____

Site Supervisor: _____ Phone No. _____
U.C./Lab Supervisor: _____ Phone No. _____
Date Request Forwarded to Div. _____ Division/Dept: _____

TO BE COMPLETED BY DIVISION/DEPARTMENT HEAD

I hereby certify that the above named employee is authorized to perform services in the State(s) of: _____
and authorize the recharging of the premium(s) for the employee's workers' compensation coverage to:
Division/Dept: _____ Recharge Acct.#: _____

Date: _____ Signature: _____

Name & Title: _____

Return completed form to: Health Services, Workers' Comp. Coordinator
MS #26-143